[redacted]

For the past 2 years I have had a host of symptoms and seen many specialists in an attempt to receive an accurate diagnosis for them. The specialists are wonderful and thorough ruling out many diagnoses. Unfortunately, I am still left with symptoms and pain. My current signs and symptoms began in January of 2009 and are getting progressively worse affecting my day-to-day activities.

SYMPTOMS

- Sharp excruciating, pinching pain that travels from my left clavicle up through my ear into the left side of my head.
- Intensifies after contrast material, any kind of physical activity even low intensity.
- Feels like a hot poker or an ice pick, very full and pressured.
- Can visibly see the left artery pulsing from time to time
- Tingling in arms and feet at night lying down.
- Eye twitches and tingling on left side of face from above the eye to below the chin.
- Swelling—in left clavicle, subclavian area
- Swooshing—started in January 2009 and has never stopped, unless I press the artery under the left ear lobe.
- Spikes in BP

FINDINGS

- Fully looped left carotid artery and tortuous right carotid artery (Per Dr. Olin, Mt. Sinai)
- Mass noted on left side of neck (8-13-10 CTA of Neck and Chest, MRI & MRA 9-2010)
- Asymmetry due to15 mm leg length discrepancy

TIMELINE OF CURRENT SYMPTOMS AND PROFESSIONALS SEEN

Jan 2009: Swooshing sound in ears

- Sounds exactly like my heart beat (like a heart ultrasound)
- Has never gone away
- In the past was primarily positional—with lying down, by turning my head to the right, bending over or when I shifted my pelvis/hips back.
- Progressively getting worse—hear it almost all of the time and almost any position
- Worse when lying down—louder and constant

Feb 10, 2009: Debilitating headache (PCP, Dr. Wenick)

- Prescribed Zomig Nasal Spray, in which I felt an odd heaviness between my shoulder blades
- Diagnosed with a migraine
- MRI following day

Feb 25, 2009: Neurologist (Dr. Wirz—Associated Neurologist)

- Diagnosed with tinnitus and probable migraine
- Ordered MRA

Feb 2009: ENT (Dr. Bloch)

- Saw an ENT who performed a hearing test and ordered MRV
- Never received a formal diagnosis

August 19, 2009: ENT (Dr. Vining)

- Sought second opinion
- Diagnosed with pulsatile tinnitus related to mild sensorineural hearing loss and eustachian tube dysfunction

Jan 13, 2010: Vascular (Dr. Olin—Mt. Sinai)

- Duplex Ultrasound—Renal Arteries, Bilateral
- Carotid Duplex Ultrasound—Bilateral
- Ordered bloodwork
- Ordered RA CTA Neck with and without IV Contrast
- Ordered RA CTA Chest Abdomen Pelvis with and without IV Contrast
- Ruling out Fibromuscular Dysplasia (FMD)

Jan 22,2010: Left side neck and head pain starts and never leaves

- Relentless, sharp focused pain about an inch in width along my clavicle straight up through my earlobe straight into the left side of my head.
- Gets progressively more intense with any activity I engage in.
- I have taken Naproxen 500 mg 2 times a day for a month with no relief
- Nothing has stopped the pain

Feb 9, 2010: Vascular Follow-up (Dr. Olin)

- No FMD of renals or mesenteric vessels
- No aneurysms in the abdomen
- Severe tortuosity of the carotid arteries left greater than right. Complete loop on the left
- Dilatation of subclavian arteries bilaterally at 1.2 cm
- Plan was a return for CTA of carotids and intercranial circulation, duplex ultrasound and genetic testing

Feb 18, 2010: Neurologist (Dr. Bonwetsch—Associated Neurologist)

- Diagnosed Cervicalgia
- Prescribed Tizanidine 4mg (1 tab 2x/day as needed)—no relief when took
- Gabapentin 300 mg—never took due to concerns about side effects

Feb to May 2010: Spikes in Blood Pressure

- From 97/66 to 180/100

March 21, 2010: Emergency Room Danbury Hospital (Dr. Bazuro)

- Blood Pressure spiked to 181/100
- Intensified pain in neck pain
- EKG done—normal
- CT Angiography of Neck with and without IV Contrast
- CT Head/Brain without Contrast
- IV fluids
- IV Dilaudid .5mg
- IV Toradol 30mg
- Medicines did not touch the pain
- My PCP was called and they wanted me to start high blood pressure medications.

March 2010: Vascular Phone Consult (Dr. Olin)

- After ER visit with spike in BP was prescribed Cozaar 50 mg

April 2010: Gynecological (Dr. Malley)

- Felt inflammation and swelling from the clavicle to upper breast area.
- Ordered Bilateral Breast Ultrasound and Digital Mammogram
- Nothing gynecological was the cause of the swelling

April 2010: Endocrinologist (Dr. Tuttle)

- Upon physical exam did not find palpable mass in thyroid area

April 21, 2010: Emergency Room Danbury Hospital (Dr. Muratori)

- Went due to spike in BP
- Intensified neck pain
- EKG done—normal

April 29, 2010: Emergency Room Danbury Hospital (Dr. Hsu)

- For same symptoms of Spike in BP and extreme, intense neck pain that travels up to the head.
- Blood work: CBC with Auto Diff (Lytes, BUN, Creat, Glu Group)

May 5, 2010: Vascular Follow-up (Dr. Olin)

- Review of RA CTA Head with and without Contrast & Ultrasonography of Upper Extremity Arteries—Bilateral
- Not seeing typical FMD
- Subclavian arteries are 30-40% larger than normal on the left side—thinks underlying genetic disease could cause it.
- No aneurysm or stenosis present
- Carotid arteries are a bit larger
- Prescribed Beta Blocker—Tenormin 25mg to see if it would help alleviate swooshing/pulsating sound
- Ordered genetic testing due to family history of aneurysm (father had 2 and brother had an aortic repair and needed a St. Jude valve).

June 9, 2010: Orthopedic (Dr. Bostrom)

- Treating my leg length discrepancy
- Did not feel the leg length was contributing to swooshing or pain symptoms

June 14, 2010: Massage

- Gentle neck massage
- Increase in pain intensity

June 29, 2010: Neurologist (Dr. Szabo)

- Palpitated a mass on left side of neck—wanted Endocrinologist to rule out cancer
- Ruling out torticollis (recommended Botox injections)
- Prescribed Diamox 250mg—had side effect of tingling in lips and did not help any symptoms.

July 6, 2010: Rheumatologist (Dr. Diep)

- Examined the area and noted the swelling and inflammation and wanted to rule out the recurrence of cancer.

July 28, 2010: Emergency Room Danbury Hospital (Dr. Plant)

- Symptoms intensified—pain and swelling
- BP 139/83
- EKG—normal
- IV Dilaudid .5mg (2 doses)
- IV Zofran 4 mg
- IV Toradal 30mg
- Chest X-ray—normal
- Pain medication did not reduce symptoms and upon returning home vomited.
- Lyme test done—came back negative

August 4, 2010: Vascular Follow-up (Dr. Olin)

- Reviewed increase in symptoms
- Reviewed reports and appointments with regards to symptoms and swelling
- Ordered CTA of Neck
- Genetic testing came back negative

August 4, 2010: Head, Neck, Throat Surgeon (Dr. Shaha—MSKCC)

- Examined the swollen area but from PET scan knows not cancer
- Thinks vascular but wants more imaging CTA or MRI
- Referred back to Vascular doctor

August 10, 2010: Cardiologist (Dr. Alexander)

- Annual check-up
- Echo and Cardiogram were fine
- Thinks vascular
- Possibly take a statin like Lipitor
- Repeat lipid profile in 3 months

August 24, 2010: Vascular Consult (Dr. Olin)

- Discussed CTA and the mass seen.
- Referred me to a head and neck specialist
- Does not feel symptoms vascular in nature

August 27, 2010: Endocrinologist (Dr. Tuttle)

- Annual check up
- PET scan normal—mass on left side not cancerous
- Ultrasound shows watching nodules in the RT soft tissue (.5cm is biggest one), no change from previous year
- Blood work is fine
- Will perform a Chest CT without contrast in 3 months, then 6 months, then 1 year, as well as repeat the ultrasound and blood work to ensure nothing cancerous.

SIGNIFICANT MEDICAL HISTORY

4-19-00: Thyroidectomy (Yale New Haven—Dr. Kinder)

- 2cm papillary thyroid carcinoma with multiple nodules

5-10-00: Radioactive Iodine Treatment (Yale New Haven)

- 278.9 mCi of I-131 orally

10-03-00: Radical Neck Dissection (Memorial Sloan Kettering Cancer Center)

- 3 out of 64 lymph nodes positive for papillary thyroid carcinoma largest of which was 1.5cm.

1-29-03: Radioactive Iodine Treatment (Memorial Sloan Kettering)

- 314.5 mCi of I-131 orally

12-6-2005: Right Total Knee Replacement (UCONN Health Center, Dr. Lewis)

- Left with 15mm leg length discrepancy (totally even legs prior)
- 12 mm lift placed on inside of shoe for 4 ½ years. Switched to 12 mm insert on entire bottom of shoe in May 2010.
- Steady course of chiropractic care, 3 times a week post surgery due to pelvic imbalance which caused neck, back and hip pain (none prior to surgery)

Other surgeries:

- Breast lumpectomies
- RT ovary removed 2001
- RT knee surgeries since high school
- Ulna Osteotomy

RECENT TESTS

4-13-09: Cerebrovascular Duplex Scan (Danbury Hospital)

6-17-09: Stress Echo (Cardiac Specialists)

2-11-09: MRI of Brain and Internal auditory canals (Danbury Hospital)—7mm nonspecified right cerebellar lesion.

3-9-09: MRA of Head without contrast (Danbury Hospital)

6-24-09: MRI Brain with and without IV Contrast (Memorial Sloan Kettering)—no lesion seen.

7-16-09: MRV of Brain with and without IV Contrast (Danbury Hospital)

1-13-10: Duplex Ultrasound—Renal Arteries, Bilateral (Mt. Sinai)

1-13-10: Carotid Duplex Ultrasound—Bilateral (Mt. Sinai)

1-22-10: RA CTA Neck with and without IV Contrast (Mt. Sinai)

1-22-10: RA CTA Chest Abdomen Pelvis with and without IV Contrast (Mt. Sinai)

2-24-10: MRI of Cervical Spine (Northeast Radiology)

3-21-10: CT Angiography of Neck with and without IV contrast (Danbury Hospital/ER)

3-21-10: CT Head/Brain without contrast (Danbury Hospital/ER)

4-2-10: MRI Brain (Memorial Sloan Kettering)—no lesion seen (year follow-up to 2-09 MRI)

4-8-10: Bilateral Breast Ultrasound and Digital Mammogram (Northeast Radiology)

5-3-10: RA CTA Head with and without contrast (Mt. Sinai)

5-3-10: Ultrasonography of Upper Extremity Arteries—Bilateral (Mt. Sinai)

7-8-10: Body FDG PET/CT (Memorial Sloan Kettering Cancer Center)

8-13-10: RA CTA Chest with and without IV contrast (Mt. Sinai)

LABS

1-13-10: Mt. Sinai
5-3-10: Mt. Sinai
6-23-10: Genetic Testing for COL3AI gene & TGF beta 1 & 2—Collagen Diagnostic Laboratory
7-7-10: Glucose test—Memorial Sloan Kettering
7-14-10: Danbury Medical Group—high sed rate and high CPR
8-19-10: T4—Memorial Sloan Kettering
8-19-10: TSH & Thyroglobulin total and antibody—Memorial Sloan Kettering

FAMILY HISTORY

Father: Thoracic Aneurysm and Aneurysm leading into the kidneys. Ended up on renal dialysis and died at age 62.

Brother: Aneurysm requiring a St. Jude Valve

Paternal Uncle: Myocardial Infarction

Maternal Grandmother: Myocardial Infarction

Danbury Hospital

24 Hospital Avenue
Danbury, CT 06810
(203) 739 - 7213

Patient: [redacted]
Med Rec Number: [redacted]
Financial Number: [redacted]
DOB/Age/Sex: [redacted] 54 years Female
Location: RADIOLOGY MRI - -
Consulting Provider(s): Wenick, Diane F Tuttle, Robert M; Wenick, Diane F

Copy To: N/A
Ordering Provider: Wenick, Diane F
Admitting Provider: Wenick, Diane F

Magnetic Resonance Imaging

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	MRI Brain w/ + w/o Contrast	11 Feb 2009 20:07 EST	Wenick, Diane F

Report

MRI OF THE BRAIN AND INTERNAL AUDITORY CANALS, 02/11/09

CLINICAL INFORMATION: New onset migraines. "Whooshing sound in left ear". History of thyroid cancer.

There is a 7 mm oval, somewhat lobulated lesion in the right cerebellar hemisphere which enhances prominently after contrast administration. It is vaguely perceptible on T2 weighted images, manifesting increased signal and there actually appears to be corresponding restricted diffusion. No hydrocephalus is evident. No extraaxial fluid collections, intracranial hemorrhages or intracranial mass lesions are present. There is relatively mild increased signal on T2 weighted images in portions of the cerebral hemispheric white matter, but there is a somewhat thick rind of signal abnormality in the left periatrial white matter without corresponding restricted diffusion or abnormal enhancement after contrast administration. No other abnormal brain enhancement is evident. There is no cerebellopontine angle mass, nor abnormal enhancement within either internal auditory canal.

IMPRESSION:

1. 7 mm nonspecific enhancing right cerebellar lesion. A variety of etiologies are possible, including metastatic disease, although it would be quite rare for thyroid cancer to manifest with brain metastases.

2. Signal abnormality in the cerebral hemispheric white matter is relatively mild and nonspecific in appearance, but there is a thick rind of signal abnormality in the left periatrial white matter. While small vessel ischemic changes are still probably the most likely etiology, a variety of etiologies are possible and clinical correlation is recommended.

3. No MRI evidence of so-called acoustic neuroma.

Danbury Hospital

Patient: [redacted]
Med Rec Number: [redacted] Copy To: N/A

Magnetic Resonance Imaging

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	MRI Brain w/ + w/o Contrast	11 Feb 2009 20:07 EST	Wenick, Diane F

4. The findings were discussed with Dr. Diane Wenick at 9:10 AM on 2/12/09.

***** Final *****

DICTATED BY: Bottger, Bradford
SIGNED BY: Bottger, Bradford
Danbury Radiology Associates, P.C.
Dictated: 02/12/2009
Signed: 02/12/2009

Danbury Hospital

24 Hospital Avenue
Danbury, CT 06810
(203) 739 - 7213

Patient: [redacted]
Med Rec Number: [redacted]
Financial Number: [redacted]
DOB/Age/Sex: [redacted] 55 years Female
Location: EMR DEPART - -
Consulting Provider(s): Bazuro, Robert Wenick, Diane F

Copy To: N/A
Ordering Provider: Bazuro, Robert
Admitting Provider: Bazuro, Robert

Computerized Tomography

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	CT Head or Brain w/o Contrast	21 Mar 2010 13:20 EDT	Bazuro, Robert

Report

CT BRAIN WITHOUT IV CONTRAST, 03/21/10

CLINICAL DATA: Headache. Hypertension. History of thyroid cancer.

Emergency exam was performed obtaining contiguous axial sections from foramen magnum to vertex, without IV contrast administration. Correlation is made with prior DH imaging.

The visualized skull and sinuses are unremarkable. There is asymmetry in size of the occipital horns, a long term stable appearance, a mild developmental variant. Ventricular system and remainder of CSF spaces show no significant abnormality. There is no extra-axial mass or fluid collection evident, and no midline shift. No parenchymal hemorrhage or mass effect is seen.

IMPRESSION:

No intracranial hemorrhage or mass effect identified, and accounting for difference in modality, appearance is stable compared to DH brain MRI exam of 02/11/09. Of note, subtle findings described on that prior MRI report are not visible on this CT exam.
***** Final *****

DICTATED BY: Hulnick, Donald
SIGNED BY: Hulnick, Donald
Danbury Radiology Associates, P.C.
Dictated: 03/21/2010
Signed: 03/21/2010

Danbury Hospital

24 Hospital Avenue
Danbury, CT 06810
(203) 739 - 7213

Patient: [redacted]
Med Rec Number: [redacted]
Financial Number: [redacted]
DOB/Age/Sex: [redacted] 54 years Female
Location: RADIOLOGY MRI - -
Consulting Provider(s): Wirz, Diane Kovacs, Karen F; Wenick, Diane F

Copy To: N/A
Ordering Provider: Wenick, Diane F
Admitting Provider: Wirz, Diane

Magnetic Resonance Imaging

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	MRA Head w/o Contrast	09 Mar 2009 13:24 EDT	Wenick, Diane F

Addendum
The correct ordering provider is Dr. Diane Wirz.

***** Final *****

DICTATED BY: Lawler, Gregory
SIGNED BY: Lawler, Gregory
Danbury Radiology Associates, P.C.

Signed: 03/10/2009
Transcribed by: CH

Report
MRA HEAD WITHOUT CONTRAST

HISTORY: Tinnitus.

TECHNIQUE: 3-D Time of Flight MRA of the entire head was performed on an ultra high field 3 Tesla MRI scanner.

FINDINGS: The study is normal. There is no vascular malformation, intracranial stenosis, or aneurysm evident. No abnormal vascular loop is evident. There is a normal caliber of the basilar artery in both posterior cerebral arteries as well as the anterior and middle cerebral arteries. There is normal flow signal within the cavernous and supraclinoid segments of the internal carotid arteries.

IMPRESSION:

Normal MRA of the head.

Danbury Hospital

24 Hospital Avenue
Danbury, CT 06810
(203) 739 - 7213

Patient: [redacted]
Med Rec Number: [redacted]
Financial Number: [redacted]
DOB/Age/Sex: [redacted] 54 years Female
Location: RADIOLOGY MRI - -
Consulting Provider(s): Bloch, Dov C Wenick, Diane F; Tuttle, Robert M

Copy To: N/A
Ordering Provider: Bloch, Dov C
Admitting Provider: Bloch, Dov C

Magnetic Resonance Imaging

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	MRA Head w/ + w/o Contrast	16 Jul 2009 13:47 EDT	Bloch, Dov C

Report

MRV

HISTORY: Headaches.

MRV of the brain was performed utilizing 15 cc MultiHance intravenous contrast agent on a 3 Tesla magnet. Comparison is made to the prior study dated March 9, 2009.

FINDINGS: Post contrast reformatted images of the brain demonstrate enhancement within the central sinus, transverse sinuses, sigmoid sinuses, major cortical veins, internal cerebral veins, vein of Galen, straight sinus, vein of Labbé, and petrous sinuses.

Limited evaluation of the COW arteries demonstrate the right internal carotid artery appears uniform in caliber. Within the petrous segment, there is uniform caliber.

There is no definite evidence of aneurysm involving the supraclinoid portion of the ICA. No aneurysm is seen at the ICA/MCA junction on the right.

The right A1 segment appears normal.

There is a small posterior communicating artery. No aneurysm is identified within the PCA.

The left internal carotid artery appear uniform in caliber including the vertical segments and petrous segments. There is no evidence of aneurysm emanating from the supraclinoid portion of the internal carotid artery. No aneurysm is identified at the ICA/MCA junction.

The A1 segment appears patent.

The posterior circulation demonstrates a patent basilar artery. There is no evidence of aneurysm involving the top of the basilar artery. The posterior cerebral arteries appear symmetric.

IMPRESSION:

Limited evaluation of the COW demonstrates no evidence of abnormality.

Danbury Hospital

Patient: [redacted]
Med Rec Number: [redacted] Copy To: N/A

Magnetic Resonance Imaging

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	MRA Head w/ + w/o Contrast	16 Jul 2009 13:47 EDT	Bloch, Dov C

Patent venous dural sinuses.

***** Final *****

DICTATED BY: Santoro, Joseph
SIGNED BY: Santoro, Joseph
Danbury Radiology Associates, P.C.
Dictated: 07/16/2009
Signed: 07/16/2009

Ear Nose Throat
MEDICAL AND SURGICAL GROUP, LLC

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August 19, 2009

Diane Wenick, M.D. (Via fax 203/794-1796)
132 Main Street
Danbury, CT 06810

RE: [redacted]

Dear Dr. Wenick,

Thank you for your kind referral of [redacted], a 54-year-old behavioral health clinician with a history of pulsatile tinnitus in her left ear. The patient states that she has had these symptoms for approximately 6 months and has found that it will shift with changes in her head position. She notes that putting pressure on her neck will actually stop the noise. She denies any significant hearing loss and, actually, saw Dr. Bloch, who performed an audiogram to confirm this. She has had a preceding severe headache so severe that she excused herself from an appointment with a client. This led to an MRI of her brain, which initially was read as having a left temporal lesion. A follow-up MRI at Sloan-Kettering where she is followed for her thyroid cancer failed to reveal that lesion. The patient also had an MRA, which did not show any vascular loops or vascular abnormalities. The patient has had a lot of neck manipulation by her chiropractor but denies any significant hearing loss or noise exposure. She denies any chronic sinus problems.

Her past medical history is notable for papillary cancer of the thyroid diagnosed in 2000. She has had a thyroidectomy, 2 treatments with radioactive iodine and a neck dissection performed later when she was found to have neck nodes. She is status post multiple other surgeries including a right knee replacement in 2005, right ulna osteotomy in 1994 and right knee ligament surgery in 1973 and 1990. She also is status post a complex ovarian cyst in 2003.

Her medications include Synthroid, estradiol, a multivitamin and calcium as well as vitamin D. She has no known drug allergies. She works as a behavioral health clinician. She does not smoke. She has wine maybe once a month. Her family history and review of systems are, otherwise, unremarkable.

On examination, her blood pressure is 117/78 with a heart rate of 62. She is 5 feet 5 and 165 pounds for a body mass index of 28. Her ear, nose and throat exam was entirely normal including normal hearing exam, normal tuning forks and no evidence of any carotid bruits.

Rather than repeat a hearing test, I did obtain the records from Dr. Bloch's office. It showed a mild difference at 8,000 Hertz between the left and right ear with the left showing a threshold of 35 decibels and the right being at 20 decibels. Her speech discrimination was excellent. Her tympanograms also demonstrated a negative-pressure tympanogram on the left where as the right was normal.

I have reviewed these findings with [redacted] and feel that she has pulsatile tinnitus related to a mild sensorineural hearing loss and eustachian tube dysfunction. She has been doing autoinflation, and I have given her a handout from the American Tinnitus Association with recommendations. She should have an annual audiogram and let us know if she has any changes. I am sorry that I do not have a clear solution to her problem, but I think you have done a nice job at ruling out any of the more serious problems that can cause pulsatile tinnitus.

I will continue to keep you updated on any further contact I have with her.

Yours very truly,

Eugenia M. Vining, M.D., FACS

EMV/ITS/5310/232606

Jeffrey W. Olin, D.O.
Professor of Medicine (Cardiology)
Director, Vascular Medicine
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E-mail: jeffrey.olin@msnyuhealth.org

JEFFREY W OLIN, DO 1/13/10 08:27 PM Signed

VASCULAR MEDICINE CONSULTATION

Patient seen and examined with Joe Lau, M.D., Ph.D. Cardiology Fellow. Note modified as below:

[redacted] is a 54 year old woman who presents for evaluation of fibromuscular dysplasia.

[redacted] has a history of thyroid cancer and had undergone radioiodine treatment, with right neck mass resection and lymph node dissection ten years ago at Sloan-Kettering. Over the past year, she has noted hearing a swooshing noise in both ears at night. With her family history of aortic aneurysms, she is concerned that she may have FMD. She saw an article in the Wall Street Journal about FMD and our program.

She recalls that her father, who was an extensive alcohol and tobacco user, required aortic aneurysm surgery at age 62. He later developed renal failure, and died from complications related to end-stage renal disease. Her father also had evidence of renal artery aneurysms. Her brother also has a history of aortic aneurysm, and recently underwent aortic valve replacement and resection of abdominal aortic aneurysm (Yale University) at age 53. Her paternal grandfather died suddenly at age 62 from what was believed to be a myocardial infarction.

Last March, [redacted] had several episodes of intense headaches. An MRI/MRA/MRV of her brain performed at Yale was unremarkable. Her carotid arteries were not evaluated. [redacted] denies having headaches recently, and also denies a history of amaurosis fugax, TIA, or stroke.

There is no history history of hypertension, claudication, TIA, or stroke.

[redacted] mentioned that she is positive for Factor V Leiden mutation. She does not have a history of venous or arterial thrombosis. Her mother and aunt both had DVTs.

Current outpatient prescriptions

Medication	Sig

• Levothyroxine Sodium (SYNTHROID) 150 mcg Oral Tab	Take 150 mcg by mouth daily.
• ETHINYL ESTRADIOL ORAL	Take by mouth.
• PROGESTERONE MISC	Use.

Review of patient's allergies indicates no known allergies.

Patient Active Problem List

Diagnoses	Code
• Thyroid Cancer	193A
• Arterial Fibromuscular Dysplasia: Carotid Arteries	447.8AQ
• Factor V Leiden Mutation: Heterozygote. No previous venous thrombembolism.	289.81M

Past Surgical History

Procedure	Date
• Hx total knee arthroplasty	*right*
• Hx ovary removal	*left ovary removal for cyst 2003*

Social History:

Social worker

Quit tobacco use 28 yrs ago.

Social alcohol use, denies drug use.

Family History:

As stated in HPI

Review of Systems: Negative except as listed above.

Physical Exam:

The weight is 79.38 kg. The patient was oriented to time, place and person. The blood pressure is 140/80 mmHg bilaterally. There was no cervical lymphadenopathy. The thyroid gland was not enlarged. There is well-healed scar in her right neck indicative of prior surgery. There were no subclavian or carotid bruits. Carotid pulses were normal and equal bilaterally. The heart rate and rhythm was regular, without murmurs. The lungs were clear to auscultation bilaterally. The abdomen was obese, soft, nontender. There were no abdominal bruits present. There were no abdominal masses. The aorta was palpable, nontender, and not enlarged. There is a well-healed scar over her left knee indicative of prior knee replacement. Patellar and Achilles deep tendon reflexes were present.

Pulse	**Right**	**Left**
Carotid	normal	normal
Radial	normal	normal
Femoral	normal	normal
Popliteal	normal	normal
PT	normal	normal
DP	normal	normal

Diagnostic Testing:

Carotid Duplex Ultrasound (1/13/10):

RIGHT:

Internal Carotid Artery:

There was tortuosity in the mid and distal internal carotid artery suggestive of fibromuscular dysplasia.

LEFT:

Internal Carotid Artery:

There was tortuosity in the mid and distal internal carotid artery suggestive of fibromuscular dysplasia.

Bilateral Renal Ultrasound (1/13/10):

RIGHT RENAL ARTERY:

Findings consistent with a 0-59% stenosis. Patent without evidence for significant renal artery stenosis.

There is tortuosity in the mid to distal segment.

LEFT RENAL ARTERY:

Findings consistent with a 0-59% stenosis. Patent without evidence for significant renal artery stenosis.

There is tortuosity in the mid to distal segment.

Assessment:

1. Possible fibromuscular dysplasia in bilateral carotid and renal arteries.

2. Family history of aortic aneurysms.

Plan:

1. Check CBC, SMA, and lipid panel.

2. Obtain CD images of her recent head MRI/MRA from Yale. We are specifically looking to rule out the presence of intracranial aneurysms which may occur in patients with FMD.

3. Obtain CT angiogram of the chest, abdomen, and pelvis to rule out the presence of aneurysms or dissections.

4. Obtain a CT angiogram of her carotids. This will likely be performed separately from her other CTA.

5. Recommend genetic testing for COL3A1 (Ehlers-Danlos, vascular type) and TGF-beta receptor (Loeys-Dietz syndrome). Will arrange at a later date.

6. No neck manipulations in future, as this may increase her risk for developing or carotid artery dissections.

7. She will provide a copy of her father's autopsy report and brother's operative report (when he underwent aortic valve replacement).

Letter to:

Diane Wenick, M.D.

Danbury Medical Group

132 Main Street
Danbury, CT 06810-7863

Copy to:

Jonathan Alexander, M.D.

24 Hospital Avenue
Danbury, CT 06810-6099

Jeffrey W. Olin, D.O.
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E-mail: jeffrey.olin@msnyuhealth.org

JEFFREY W OLIN, DO 2/10/10 03:07 PM Signed

[redacted]

Vascular Medicine Follow Up

I reviewed patients outside imaging studies and the records she had sent to me. I also reviewed the CT angiogram from Mount Sinai.

Summary of findings:

1. No FMD of renals, or mesenteric vessels.

2. No aneurysms in the abdomen.

3. There is severe tortuosity of the carotid arteries, left greater than right. There is a complete loop on the left. The only symptoms related to this is swooshing sound in ears.

4. Dilatation of the subclavian arteries bilaterally at 1.2 cm.

5. We did not get good views of the distal ICA bilaterally. And while we did not see clearcut evidence of FMD, we must look at entire artery.

Current outpatient prescriptions

Medication	Sig	Dispense	Refill
• Levothyroxine Sodium (SYNTHROID) 150 mcg Oral Tab	Take 150 mcg by mouth daily.		
• ETHINYL ESTRADIOL ORAL	Take by mouth.		
• PROGESTERONE MISC	Use.		

No Known Allergies

BP 140/90 | Wt 157 lb (71.215 kg)

I spent about 35 minutes speaking with the patient, her partner and her mother. I answered all of their questions. The only indications for surgery for the severe carotid loops are:

1. Amaurosis fugax, hemispheric TIA or stroke
2. Swooshing sound that is so severe and so debilitating to her lifestyle that she cannot function. She tells me it is no where near this level.
3. Development of aneurysm.

Assessment:

1. Bilateral severe tortuosity (full loop) in the carotid arteries (left >right)... We have seen this in patients with FMD but can also be seen in TGF beta mediated conditions.

2. Possible dilatation of the subclavian arteries.

3. Factor V Leiden heterozygote: Asymptomatic

4. History of thyroid cancer

5. Family history (brother) of ascending aortic aneurysm and (mother) descending thoracic aneurysm. Must rule out:

A. Ehlers Danlos Type IV

B. Abnormalities of TGF beta e.g. Loeys-Dietz Syndrome.

Plan:

1. Return in July for:

A. CT angio of the carotids and intracranial circulation.

B. Duplex Ultrasound of subclavian artery for size:

B. See me.

2. Send blood for:

A. COL3AI gene

B. TGF beta 1 and 2

Letter:

Diane Wenick, MD

Danbury Medical Group

132 Main Street

Danbury, CT 06810-7863

Jonathan Alexander

24 Hospital Avenue

Danbury, CT 06810

Jeffrey W. Olin, D.O.
Professor of Medicine (Cardiology)
Director, Vascular Medicine
Zena and Michael A. Wiener Cardiovascular Institute and
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E-mail: jeffrey.olin@msnyuhealth.org

JEFFREY W OLIN, DO 5/5/10 04:30 PM Signed

[redacted]

VASCULAR MEDICINE FOLLOW-UP VISIT NOTE

Patient seen and examined with Dr. Joe Lau. Note modified as below. We spent more than 45 minutes with [redacted] and her friend and mother and reviewed all tests, viewed the CT angiogram and outside CT scans and counseled her on what she can and cannot do.

Since her last visit with us, she has noted several episodes of left neck-area tenderness, pulsatile feeling in her neck, headaches and elevated blood pressures that have prompted her to visit the ED at Danbury Hospital on three occasions. She denies having symptoms consistent with TIA, stroke, or amaurosis fugax. During these episodes, which appear to also be associated with increased stress and anxiety, her BPs are ~180s/100s. We started her on Cozaar 50 mg daily, and her random home BPs have been 110-130s/70-80s with a heart rate around 60-70s bpm. The blood pressures have been excellent over the last week.

On her first ED visit in March, a CTA of her head and neck was performed. The radiology report suggested that there may be aneurysmal dilations in both the left and right internal carotid arteries, but on our review of this study, we could not clearly identify these aneurysms.

An upper extremity arterial ultrasound was also performed on 5/3/10 because an earlier CTA of her head and neck from January had identified bilateral subclavian artery dilatation (~1.2 cm in diameter). Again, on our ultrasound, both subclavian arteries appeared ectatic rather than aneurysmal (normal subclavian artery diameter in an average-sized person is ~0.5-0.7 cm). A CTA of her head and neck performed here on 5/3/10 did not identify intracerebral aneurysms, and also did not identify classical types of FMD in her carotid and vertebral arteries.

She submitted bloods for genetic testing for Ehlers-Danlos vascular type and Loeys-Dietz this past week.

Current outpatient prescriptions

Medication	Sig	Dispense	Refill
• losartan (COZAAR) 50 mg Oral Tab	Take 50 mg by mouth daily.		
• NAPROXEN (NAPROSYN ORAL)	Take by mouth as needed. Neck pain		
• atenolol 25 mg Oral Tab	Take 1 Tab by mouth daily.	30 Tab	11
• Levothyroxine Sodium (SYNTHROID) 150 mcg Oral Tab	Take 150 mcg by mouth daily.		
• ETHINYL ESTRADIOL ORAL	Take by mouth.		
• PROGESTERONE MISC	Use.		

No Known Allergies

Review of Systems: Negative except as listed above.

Physical Exam:

The weight is 74.84 kg. The blood pressure was initially 160/85 mmHg in both arms, but was 140/75 mmHg later during exam. There was no cervical lymphadenopathy. The thyroid gland was not enlarged. Well-healed scar on her right neck area. Carotid pulses were normal and equal. There was mild tenderness to palpation over the left neck area. There was no temporal tenderness. There were no subclavian or carotid bruits bilaterally. There was no JVD. The heart rate and rhythm was regular, without murmurs. The lungs were clear to auscultation. There was no edema and the pulses were normal. The skin was normal.

Diagnostic Testing:

Labs:

LDL 123, HDL 50

Upper extremity ultrasound 5/3/10:

RIGHT SUBCLAVIAN ARTERY:

The artery is dilated at the vessel origin (1.3 cm to 1.04 cm distal to origin).

Patent artery without evidence for significant stenosis.

LEFT SUBCLAVIAN ARTERY

The artery is dilated immediately distal to the clavicle (1.1 cm to 0.87 cm distal to dilation).

Patent artery without evidence for significant stenosis.

CTA head/neck 5/3/10:

No intracranial aneurysm present. Although an otherwise limited study, there was no obvious evidence for aneurysm, dissection, or stenosis in bilateral carotid and vertebral arteries.

Assessment:

1. Arterial vasculopathy of unclear etiology. With her family history of aortic aneurysm and dissections, and her unusual arterial characteristics (i.e., left internal carotid loop and dilated subclavian arteries), this may be connective tissue disease. Differential includes genetic disorders such as Marfan's syndrome, cystic medial necrosis, or one the TGF-beta disorders (i.e. Loeys-Dietz) or Ehlers-Danlos vascular type. If this is FMD, this is not one of the classical forms.

2. Hypertension: This needs to be under better control.

3. Left-sided pulsatile tinnitus and neck area pain: The tinnitus and swooshing is likely related to turbulent flow within the left internal carotid loop. The pain cannot be explained by this.

Plan:

1. Add atenolol 25 mg daily and titrate as needed. Continue Cozaar 50 mg daily.

2. Check random blood pressures and heart rate twice daily. One of her readings should be while she is at work.

3. Follow-up on genetic tests.

4. She will provide us the pathology reports from her brother's aortic surgery.

5. She was informed that taking Naprosyn or any other NSAIDs can also increase her BPs and its use should be monitored.

6. Return visit in six months:

A. Blood tests including CRP

B. Check echo to assess aortic root.

C. Duplex carotids and renals

D. Visit with me.

Letter to:

Diane Wenick, MD

Danbury Medical Group

132 Main Street

Danbury, CT 06810-7863

Jonathan Alexander

24 Hospital Avenue

Danbury, CT 06810

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JEFFREY W OLIN, DO 8/4/10 12:34 PM Signed

[redacted]

VASCULAR MEDICINE FOLLOW UP

55 year old female here for a follow-up for severe pain in left subclavian area to head. The pain is constant but has different degrees of intensity. The intensity becomes more severe with physical activity. The pain usually intensifies as the day progresses. There is also swooshing in her left ear which is mostly constant. She called last Wednesday, 7/28/10, because of intense pain in neck and head. She went to her local emergency room where they gave her an injection of IV dilaudid and Toradol which relieved the pain for approximately 2 hours. She is currently not taking NSAIDS or other pain medications. She has been applying ice as needed to her left clavicle area with minimal relief. The clavicle becomes very swollen at times. She recently was seen by Dr. Jenny Diep who did not believe the patient had a connective tissue disorder. Patient has gained 20 pounds since January 2010 because of decrease in exercise. Her blood pressures at home have been well controlled with systolic blood pressures between 100-120 mmHg.

A Pet /CT scan was performed to evaluate her neck for a recurrence of thyroid cancer. This test was negative for recurrence. She had a thyroidectomy in 2002 with radiation for the cancer.

She recently had a sed rate in the 40s with a CRP ~ 2-2.5.

Outpatient prescriptions marked as taking for the 8/4/10 encounter (Office Visit) with OLIN, JEFFREY W

Medication	Sig	Dispense	Refill
• Aspirin 81 mg Oral Tab	Take 81 mg by mouth daily.		
• OMEGA-3 FATTY ACIDS (FISH OIL ORAL)	Take by mouth.		
• atenolol 25 mg Oral Tab	Take 1 Tab by mouth	30 Tab	11

	daily.
• losartan (COZAAR) 50 mg Oral Tab	Take 50 mg by mouth daily.
• Levothyroxine Sodium (SYNTHROID) 150 mcg Oral Tab	Take 150 mcg by mouth daily.
• ETHINYL ESTRADIOL ORAL	Take by mouth.
• PROGESTERONE MISC	Use.

No Known Allergies

EXAMINATION

BP 102/64 l Wt 175 lb (79.379 kg)

Patient is alert and oriented x 3. Blood pressure - 120/70 bilaterally.

Neck: No carotid bruits, carotid pulses are equal bilaterally,

There is a fullness in the left supra-clavicular area. It is tender and palpation Causes pain up the side of her head. This fullness is not fluctuant and is not pulsatile

Lungs: Clear bilaterally to auscultation.

Heart: S1, S2, no S3 or S4, no rubs or murmurs.

Abdomen: No abdominal bruits. No palpable masses.

Extremities: No peripheral edema. DP and PTs palpable bilaterally. Upper and lower body strength equal bilaterally. The neurological exam is normal.

Impression:

1. Left supra-clavicular mass with pain radiating to left neck - ? Etiology

Plan:

1. CTA of the neck and the chest to evaluate left supra-clavicular mass and any vascular etiology.

2. Follow-up same day CTA performed to review. We offered to do the CTA today but she needed pre-authorization.

Letter:

Dianne Wenick, MD

Jenny Diep, MD
Patricia McMullen 8/4/10 12:57 PM Addended

Letters to following physicians:

Diane Wenick, MD

132 Main Street

Danbury, CT 06810
Jonathan Alexander, MD
24 Hospital Avenue
Danbury, CT 06810
Albert Szabo, MD
Mount Kisco Medical Group
90 South Bedford Road
Mount Kisco, NY 10549

DANBURY OFFICE OF
PHYSICIAN SERVICES, PC

Vascular Surgery

Alan M. Dietzek, M.D., F.A.C.S., R.P.V.I.
Chief, Vascular & Endovascular Surgery
Linda and Stephen R. Cohen Chair in Vascular Surgery
Director, Non-Invasive Vascular Lab
Clinical Assistant Professor of Surgery
University of Vermont College of Medicine

Dahlia Plummer, M.D., F.A.C.S.
Clinical Assistant Professor of Surgery
University of Vermont College of Medicine

Richard Hsu, M.D., P.H.D.
Clinical Assistant Professor of Surgery
University of Vermont College of Medicine

Stacy Henderson, PA-C

Date: 11/19/2010

RE: [redacted]
DOB: [redacted]

Chief Complaint
• 55y/o woman seen in consultation from Drs. Wenick and Alexander. Consult is for left neck pain and finding of carotid tortuosity

HPI
Patient has undergone extensive workup for left neck pain. Over the past year, she has noted pain in base of left neck extending to posterolateral neck and posterior scalp. Recently, she has noted pulsatility in her hearing, associated with whooshing sound. Pain ha progressed to frequent. Nothing relieves the pain, including neurontin. She has also noted low midline chest pain. No SOB, DOE. No visual changes, no amaurosis, no hemispheric symptoms. Part of the workup included MRA, CTA, and duplex, all showing wide patency of intra- and extra-cranial circulation. However, tortuous bilateral ICA noted, with a 100% loop in the distal ICA. Also, 1.2cm bilateral SCA noted. Patient denies upper extremity claudication. No TMJ. No fever, chills, nausea.

Active Problems
Chest Pain (786.50)
Palpitations (785.1).

Reason For Visit
Outpatient physician consultation

PMH
Mechanical Complication Of Carotid Artery Bypass Graft (996.1).
The patient had thyroid cancer and underwent a thyroidectomy in 2002. She is currently on thyroid replacement therapy.

PSH
Status post knee replacement in December of 2005. Status post thyroidectomy in 2002 for a thyroid cancer. Status post breast surge in 1993 and 1995.

Family Hx
The patient's younger brother [redacted] recently underwent aortic root replacement. Her 77-year-old brother has hypertension and a dilated aorta. Her grandmother had hypertension.

Personal Hx
The patient is not married and has no children. [redacted] She is actively participating multiple exercise activities. She does not eat red meat. She walks 5 times a week for 45 minutes a day equaling 3 miles. She stoppe

smoking 25 years ago. Her alcohol and caffeine intake are not excessive.

Allergies

No Known Drug Allergy.

Current Meds

Synthroid 150 MCG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Cozaar 50 MG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Tenormin 25 MG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Aspirin 81 MG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Estradiol 1 MG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Prometrium 100 MG Oral Capsule;TAKE 1 CAPSULE DAILY; RPT
Multivitamins TABS;TAKE 1 TABLET DAILY.; RPT
Fish Oil 1000 MG Oral Capsule;TAKE 1 CAPSULE DAILY.; RPT.

ROS

Systemic: No fever, no chills, and no recent weight loss.
Head: Headache.
Eyes: No blurry vision.
Otolaryngeal: No hearing loss, no tinnitus, and no hoarseness.
Breasts: No breast lump.
Cardiovascular: No chest pain or discomfort and no palpitations.
Pulmonary: No dyspnea and not expressed as feeling short of breath. No cough.
Gastrointestinal: Appetite not decreased. No dysphagia, no heartburn, no nausea, no vomiting, no hematemesis, no abdominal pain and no diarrhea.
Genitourinary: No hematuria, no dysuria, and no pain during intercourse. No pregnancy.
Endocrine: No polydipsia, no heat intolerance (always Hot), and not to cold (always Cold). No flushing.
Hematologic: No tendency for easy bruising.
Musculoskeletal: No hand symptoms, no arm symptoms, no clavicle symptoms, no shoulder symptoms, no back symptoms, no hip symptoms, no leg symptoms, and no foot symptoms.
Neurological: No dizziness, no confusion, and no memory lapses or loss (forgetfulness).
Psychological: No anxiety and no depression.
Skin: No pruritus, no rash, and no sore:.

Vital Signs

Recorded by Kalbaugh,Susan on 19 Nov 2010 01:46 PM
BP:138/86, RUE, Sitting,
HR: 72 b/min, R Radial,
Height: 65 in, Weight: 182 lb, BMI: 30.3 kg/m2,
BSA Calculated: 1.90 ,
BMI Calculated: 30.29
Recorded by Mayerson,Wendy on 19 Nov 2010 08:49 AM
BP:130/80,
HR: 63 b/min,
Height: 65 in, Weight: 182 lb, BMI: 30.3 kg/m2,
BSA Calculated: 1.90 ,
BMI Calculated: 30.29.

Physical Exam

CONSTITUTIONAL:
Well NourishedWell Developed
Appears equal to stated age.

HEENT:
Head - normocephalic atraumatic
Conjuctivae - clear
Eyelids - no lesions
Pupils and Irises - equal and reactive to light and symmetric
Trachea - midline and without crepitus

Masses - none
Thyroid - s/p thyroidectomy with healed low transverse scar
Neck Lymph Nodes - not enlarged or palpable

CEREBROVASCULAR
Carotid Pulses - Right 2+ Left 2+
Bruits - none

PULSES:

Brachial	Right 2+	Left 2+
Radial	Right 2+	Left 2+
Femoral	Right 2 +	Left 2+
Popliteal	Right 2 +	Left 2+
Posterior Tibial	Right 2 +	Left 2+
Dorsalis Pedis	Right 2 +	Left 2+

Prominent bilateral subclavian arteries palpable in supraclavicular fossa.
Lipoma noted left side

CARDIOVASCULAR:
The rhythm is regular regular
S1 and S2 are noted as normal

RESPIRATORY:
Respiratory effort - normal
Auscultation - lungs clear

GASTROINTESTINAL:
Soft
Nontender
Hepatosplenomegaly - No
Hernias - No
Abdominal Aortic Aneurysm - No
Scars No
Ostomies No

GENITOURINARY:
Normal

MUSCULOSKELETAL/UPPER/LOWER EXTREMITIES:
Gait and Station: Normal
Dependent Rubor - negative
Cyanosis - negative
Venous Stasis Changes - negative
Stasis Dermatitis - negative
Induration - negative
Lymphadenopathy - negative
Ulcers and/or other Lesions - negative
Varicose Veins - negative
Spider Veins - negative
Rashes/Induration/ SubQ nodules - negative
Swelling - negative

SKIN:
Lesions/Rashes: No

NEURO:
Neuro Exam - CNs II-XII grossly intact
Neuro Deficits - No
Deep Tendon Reflexes - Yes
Sensation - Yes

PSYCHOLOGICAL:
Affect - appropriate
AAOx3 - Normal

HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC: nonpalp.

Results

Duplex, MRA, and CTA reports reviewed by me. Tortuous bilateral ICA and 1.2cm bilat SCA. No stenosis.

Assessment

- Temporal arteritis (446.5) Amended By: HSU, RICHARD 11/19/2010 19:08:28 PM EST

Orders

SED RATE ESR; Requested for: 19 Nov 2010.
CRP; Requested for: 19 Nov 2010.
Follow-up visit in 1 month; Requested for: 19 Nov 2010 Amended By: HSU, RICHARD 11/19/2010 19:08:28 PM EST.

Plan

Patient does not have evidence of cerebral ischemia. Her symptoms are classic for giant cell arteritis, and she tells me that she has ha elevated ESR and CRP in the past. There is no evidence of FMD, and genetic testing for connective tissue disorders were negative. Her pain in the left temporal area is along the superficial temporal artery distribution, and auditory symptoms are consistent with GCA. I have re-sent ESR and CRP, and I have made a referral to Dr. Rudinskaya from rheumatology. I hope that we can initiate steroid therapy, and watch for improvement in symptoms. She may need a temporal artery biopsy for diagnosis. Nothing needs to bc done for the tortuous carotid arteries. I will see her back in 1 month to monitor progression of symptoms. She will need the subclavian arteries monitored for enlargement, with a duplex in 1 year. Amended : RICHARD HSU ; 11/19/2010 7:03 PM EST.

Signature

Electronically signed by : Susan Kalbaugh MA; 11/19/2010 1:48 PM EST.
Electronically signed by : RICHARD HSU ; 11/19/2010 7:01 PM EST; Author.
Electronically signed by : RICHARD HSU ; 11/19/2010 7:03 PM EST; Author.
cc: WENICK DIANE,

DANBURY OFFICE OF
PHYSICIAN SERVICES, PC

Section of Rheumatology

Joyce Reyes Thomas, M.D.

25 Germantown Road
Danbury, Connecticut 06810
203.794.5600 phone
203.794.5611 fax

November 22, 2010

Richard Hsu, M.D., Ph.D.
111 Osborne Street
Danbury, CT 06810

RE: [redacted]
DOB: [redacted]

Dear Dr. Hsu:

Thank you very much for referring [redacted] to our office. As you know, she is a 55-year-old female with past medical history significant for thyroid cancer status post thyroidectomy and radioactive iodine treatments as well as radical neck dissection, who has had 2 years of severe left-sided head pain, for which she has seen many doctors for. She describes the pain as sharp, excruciating, pinching pain, that travels from her left clavicle up to her ear and the left side of her head. Today, she points to her left temple, as has the pain is most severe they are. The pain is constant, but there are peaked and valleys to her pain, and she thinks that any type of movement increases her pain, including eating or talking. She feels that her left eye feels "funny", but she denies any visual changes, darkness, or loss of vision. She does not have true jaw claudication. During this 2 year workup, she was found to have a Foley left carotid artery and torturous right carotid artery as well as a mass noted on the left side of her neck. Initially, the patient was thought to have migrainous headaches and possible constant sinusitis, but she had imaging which ruled these diagnoses out. She also saw a neurologist who recommended Botox injections to rule out torticollis. Vascular abnormalities she was tested for Loeys-Dietz and Ehlers-Danlos, which were ruled out. She was noted also to have an elevated ESR last July. She was seen by a rheumatologist during this time period, and examine the area of her left neck and noted the swelling and inflammation and wanted to rule out the recurrence of cancer. She denies any joint pain, except for her right knee, which was replaced because of multiple earlier sports injuries. She denies any morning stiffness, but is constantly fatigued. She was seen by you last Friday, 11/19/2010, and was told at that time that she may have temporal arteritis. Over the weekend, her pain became worse, and she went to the emergency room urgent care, and was started on prednisone 60 mg daily. She called urgently this morning for an appointment, and was seen right away. Notably, in October the patient underwent a Medrol Dosepak, which improved her symptoms, at the same time starting her on gabapentin 600 mg daily. However, after finishing the Medrol Dosepak, her symptoms returned. She was started on prednisone 60 mg daily approximately 2 days ago, and notes that she has had about a 50% reduction in her symptoms. She denies any rash, photosensitivity, pleurisy, nausea, vomiting, diarrhea, fevers, chills. She has not had any weight loss, in fact she has had weight gain. 10 point review of systems is otherwise negative.

Past Medical History: As above, significant for thyroid cancer status post thyroidectomy and radioactive ablation and radical neck dissection, status post total right knee replacement, right ovary removed in 2001, several breast lumpectomy, hypertension

Family History: Father with thoracic aneurysm and aneurysm leading to the kidneys. He denied at the age of 62 and had end-stage renal disease. Brother with an aneurysm requiring a St. Jude valve, paternal uncle had a myocardial infarction at the age of 45, paternal grandmother with a myocardial infarction at the age of 72. She denies any family history of lupus, Wegener's, Takayasu's arteritis

Social History: She denies any tobacco, alcohol, or drug abuse. She is never been pregnant or had any sexually transmitted diseases.

Medications: Aspirin 81 mg daily, Cozaar 50 mg daily, Tenormin 25 mg daily, estradiol 1 mg daily, Prometrium 100 mg daily, multivitamin, fish oil 1000 mg daily, prednisone 60 mg daily

DANBURY OFFICE OF
PHYSICIAN SERVICES, PC

Section of Rheumatology

Joyce Reyes Thomas, M.D.

21 Germantown Road
Danbury, Connecticut 06810
203.794.5600 phone
203.794.5611 fax

Allergies: No known drug allergies

Physical Exam: Blood pressure 138/86
In general the patient is an middle-aged Caucasian female in no acute distress. Sclera icteric, conjunctiva non-injected, pupils equal reactive to light and accommodation, extraocular movements intact. There is no malar rash. Temporal artery pulsations are symmetric. There is mild scalp tenderness over the left temporoparietal area. Oropharynx is clear, mucous membranes moist. There is no parotid swelling or cervical lymphadenopathy. There is a midline transverse scar over her neck. Lungs are clear to auscultation bilaterally. Heart sounds regular. Abdomen soft, nontender, nondistended. There is no clubbing, cyanosis, or edema. Strength is 5/5 in all muscle groups. She is 2+ pulses in her bilateral radial arteries. There is no tinnitus. She has good range of motion of all her joints.

Data: CT angiography neck, chest, abdomen and pelvis: Marked tortuosity of the internal carotid arteries and their proximal portions, particularly on the left. The renal arteries are mildly patent and unremarkable. A lesion of the subclavian arteries measuring up to 1.2 cm in diameter.
Renal artery ultrasound: No evidence of significant renal artery stenosis or fibromuscular dysplasia
Carotid duplex ultrasound: No elevated velocities, right internal carotid very tortuous. Left internal carotid also very tortuous.
CT angiography of the brain: No evidence of aneurysm, evidence of dissection, or significant stenosis. Callosity of the cervical internal carotid artery is associated with some contour undulation consistent with a manifestation of fibromuscular dysplasia.
2-D echo: Normal left ventricular systolic function, ejection fraction 53%. Normal right ventricular function. Atrial septal aneurysm.
TFBR1, TGFBR2 no mutation identified; COL3A1 no mutation identified
CRP 2.42, ESR 46, CBC within normal limits, comprehensive metabolic panel within normal limits

Impression:
[redacted] does not give a clear and classic story for temporal arteritis, however her symptoms are very suggestive of this possibility. She also has some scalp tenderness on the left side, which suggests that there may be some inflammation involving the temporal artery. She was already started on prednisone 60 mg, and at this point I do not want to discontinue the medication. Temporal arteritis must be ruled out by a temporal artery biopsy.

Recommendations:
- Continue prednisone 60 mg daily, divided dose into b.i.d.
- Calcium plus vitamin D while she is on steroids
- Referral to ophthalmology
- Temporal biopsy ASAP
- Check inflammatory markers today

Thank you again for this referral. It was a pleasure seeing [redacted] today and I look forward to coordinating with you in her care. Please do not hesitate to contact me with any questions.

Sincerely,

Joyce Reyes Thomas, M.D.

Cc: Diane Wenick, M.D.

Patient: [redacted] **DOB:** [redacted] **Time:** 11:32 AM
Location: Chase Clinic **Date:** 08/12/2011
Provider: Sanders, Lisa M.D. **PCP:** Sanders, Lisa
Poskus, Andrea

[redacted] - 56 year old single female referred by Lisa Sanders, M.D.

SUBJECTIVE

Patient Allergies (Poskus, Andrea) :

The patient denies any medication allergies. The patient denies any allergies to foods.

Chief Complaint (Sanders, Lisa M.D.) :

55 yo woman who presents with friend and a huge stack of medical records. Friend has complete records of paitnet's complaints and disease course.

Chief complaint is L sided head pain and "swooshing" sound in L ear.
Started in 2009. Pt was getting a chiropractic adjustment. Had had this done before. Chiro was adjusting neck b/c "occiput was out of place". And suddenly she heard this rhythmic swooshing sound in L ear. Said it sounded like an ultrasound she'd gotten in past of heart. No pain. Not dizzy or lightheaded. No change in vision. Just this noise. Was very loud. Was always present but sometimes quiet and sometime loud. Sometimes so loud it drowns out client voices.

Then got L sided headache. Came on a month after swooshing sound. Acute onset, while at work. No trauma. No instigating factors. No fever. no URI sx at the time. Nothing else going on. Had to go home and lie down. PMD prescribed zomig but caused chest pain so didn't use. Had an MRI. Nl. Dxed with migraine.

Sent to neuro. dxed with tinnitis and probable migraine.
Sent to ENT who dxed her with pulsatile tinnitis.

In Jan 2010 sought out vascular doc in NY. Read about FMD and his name mentioned. Saw him and he repeated CT and MRI that she'd had. Noted that she had a looped carotid on L.

When she was getting CT with contrast developed a headache that was very different from previous L sided headache. Felt like an ice pick that went from L side top of head down through head to neck. Pain was persistent. Never went away. Waxing and waning. Worse with activity. Worse when tinnitis is worse. Has taken NSAIDs that have been modestly helpful. Has taken narcotics but not helpful at all. Gabapentin - took that for a while but when dose got high felt bad so on a lower dose then stopped altogether.

Feels desperate.

Dxed with GCA; on high dose steroids but US and then bx neg.

Has been to ER many times.
Having spikes of bp. noted when in doctor office. Makes head hurt more. Started on antihypertensive med.

Saw vascular doc in nyc and he tested her for genetic connective tissue d/o which were negative.
Been back to the oncologist who was worried that thyroid cancer could come back on other side. Noted to have soft tissue swelling at base of L neck. BX showed lipoma.

ROS: no wt loss; sleep disturbed because of pulsing noise. vision ok. hearing ok, taste and swallowing ok. Still has occasional migraine - L sided ha; goes to sleep and feels better. meds dont' really work on it. Appetite ok. swalloing ok. No reflux. no cp; no sob; no abd pain; no pain at all assoc with food or hunger. No constipation or diarrhea. nl cycles. no problems with urination. Not sexually active at present. No rashes; no joint pain. Had knee replacement some years ago. fine since.

Medical Past History Review (Sanders, Lisa M.D.) :

Patient has a medical history of HTN
thyroid cancer; papillary ca dx 2000; s/p thyroidectomy, s/p rx with radioactive iodine x2.
Also had dissection of R neck after nodes found positive on R
hypothyroid
s/p R TKR 2005
.

Current Medications (Sanders, Lisa M.D.) :

STOPPED: Nexium 40mg Cap Dr 1 cap po qday, Entry Error
STOPPED: Indocin SR 75mg Cap Cr ONE CAPSULE PO BID WITH FOOD, Entry Error
Cozaar 50mg Tab 1 tab po qday
Synthroid 150mcg Tab 1 TABLET DAILY **Also takes several vitamins: vit b complex, Fish oil, cal/mag, Lutein, CoQ10, Vit c, Multi vitamin**

Social History (Sanders, Lisa M.D.) :

[redacted]**No tobacco, distant history; no/rare alcohol; no drugs. Used to be very athletic but now any exertion causes head pain. Big hiker; skydiving. No guns; yes seatbelts. No recent travel.**

Health Care Maintenance (Sanders, Lisa M.D.) :

Pap smear -
Pap smear date: 5-1-2010
Pap smear result: nl
Pap smear performed by: didn't ask

Mammogram: -

Mammogram date: 5-1-2010
Mammogram result: nl

Colonoscopy: -
Colonoscopy Date: 1-1-2009
Colonoscopy Result: nl
Colonoscopy Performed By: didn't ask

Family Health History (Sanders, Lisa M.D.) :

HTN, thyroid disease, CAD, brother has a ctd with aneurysm and bad valve. Inheritied?

Review of Systems (Sanders, Lisa M.D.) :

see hpi

OBJECTIVE

Vital Signs (Poskus, Andrea) :

Vitals (Adult) -
Weight (lbs): 191
Height (in): 65
Body Mass Index: 31.781
Blood Pressure (L) initial: 132/86
Pulse at Rest: 68

Vital Signs (Sanders, Lisa M.D.) :

Vitals (Adult) -
Weight (lbs): 191
Height (in): 65
Body Mass Index: 31.781
Blood Pressure (L) initial: 132/86
Pulse at Rest: 68

General Appearance (Sanders, Lisa M.D.) :

[redacted]appears well.

Skin Examination (Sanders, Lisa M.D.) :

There is no rash, swelling, redness, or other lesions involving the skin.

HEENT Examination (Sanders, Lisa M.D.) :

Normocephalic, atraumatic. PERRLA. EOMI. Fundi benign. Ears: Canals and TM's normal.

Oropharynx negative. Neck supple. No lymphadenopathy.

Neck Examination (Sanders, Lisa M.D.) :

The neck is supple. The carotid pulses are equal. There are no bruits, jugular venous distension, lymphadenopathy, tenderness,. **Soft tissue mass (lipoma???) at L base of neck. aprox 10 cm in diameter but 2-4 cm in height. Non pulsatile. No audible tinnitis. No LAN**

ASSESSMENT

Assessments (Sanders, Lisa M.D.) :

Headache , 784.0
Hypertension Benign , 401.1
Hypothyroidism Post Surgical , 244.0
Tinnitus Subjective , 388.31

General Assessment (Sanders, Lisa M.D.) :

55 yo woman with pulsatile tinnitis and stabbing L sided head pain. Not sure what this is. Also has a mass in left side of neck that has been thoroughly evaluated per pt. Pt reports that pulsatile tinnitis started when she was getting chiro adjustment. Has been thorooughly evaluated for signs of dissection. Could this be some displacement of some structure at the time of the adjustment? If so how can that be related to pain which started a year later. Carotodynia? Will review records and have pt return in 1-2 weeks for better discussion and more thorough physical exam. History took up much of this visit.

Discusssed with patient who understands why I am not ready to do anything yet.

PLAN

E&M Codes (Sanders, Lisa M.D.) :

New Patient office visit 45 minutes(moderately complex problem) , 99204

Revisit Orders (Sanders, Lisa M.D.) :

TIME UNTIL NEXT VISIT: 2-4 weeks.

ASSOCIATED PROCEDURES

New Patient office visit 45 minutes(moderately complex problem) , 99204

Headache , 784.0
Hypertension Benign , 401.1
Hypothyroidism Post Surgical , 244.0
Tinnitus Subjective , 388.31

Lab Results

Below is a list of your most recent outpatient lab results. For older lab results, click on the Lab Name. You can view a full list of the lab results available through MYMSKCC. For more information visit our Frequently Asked Questions.

Test Date	Order Name Lab Name(s)	Value [Range]	Lab Comments
07/07/2010	**Glucose (Finger Stick)**		
	Glucose (Finger Stick)	78 mg/dl [70-99 mg/dl]	
08/19/2010	**T4, Free**		
	T4, Free	2.02 ng/dl [0.9-1.8 ng/dl]	
08/19/2010	**TSH**		
	TSH	<0.02 mcUnits/ml [0.35-5.5 mcUnits/ml]	
08/19/2010	**Thyroglobulin Total and Antibody**		
	Thyroglobulin	*<0.3 This test is performed by a radioimmunoassay using reagents supplied by Brahms Diagnostica, GmbH(DYNOtest) and is not FDA approved. The Clinical Chemistry laboratory has documentation on the validation of this test.*	
	Thyroglobulin AB	<20.0 Units/ml [0-40 Units/ml]	

Patient Chart

Date Printed: 07/28/10

[redacted] 1742 Sex: F Age: 55 DOB:[redacted]

Laboratory Data - CBC

Test Name	Result	Normal Range
07/14/10 09:20 AM		
WBC	9.0 K/uL	<4.0-10.0>
GRAN%	78.2 %	<37.0-92.0>
GRAN#	7.0 K/uL	<2.0-7.8>
LYMPH%	21.8 %	<10.0-58.5>
LYMPH#	2.0 K/uL	<0.6-4.1>
RBC	4.31 M/uL	<3.70-5.10>
HGB	13.2 g/dL	<12.0-16.0>
HCT	39.2 %	<35.0-47.5>
MCV	91.0 fL	<80.0-97.0>
MCH	30.6 pg	<27.0-32.0>
MCHC	33.7 g/dL	<32.0-36.0>
PLATELET COUNT	229 K/uL	<150-400>

Patient Chart

Date Printed: 07/28/10

[redacted] 1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - CHEMISTRIES

Test Name	Result	Normal Range
07/14/10 09:20 AM		
GLUCOSE	89 mg/dL	<65-99>
ALBUMIN	4.1 g/dL	<3.8-5.5>
BUN	17 mg/dL	<7-26>
CREAT	0.9 mg/dL	<0.4-1.4>
CALCIUM	9.1 mg/dL	<8.5-10.5>
SODIUM	140 mEq/L	<135-150>
POTASSIUM	4.3 mEq/L	<3.5-5.5>
CHLORIDE	102 mEq/L	<95-110>
CO2	27 mEq/L	<23-34>
PROTEIN, TOTAL	6.7 g/dL	<6.3-8.3>
PHOSPHOROUS	4.3 mg/dL	<2.5-4.8>
URIC ACID	4.8 mg/dL	<2.5-6.8>

Patient Chart

Date Printed: 07/28/10

[redacted] 1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - HEPATIC PANEL

Test Name	Result		Normal Range
07/14/10 09:20 AM			
ALBUMIN	4.1 g/dL		<3.8-5.5>
ALK PHOS	48 IU/L		<30-103>
ALT (SGPT)	19 IU/L		<10-40>
AST (SGOT)	18 IU/L		<12-32>
BILIRUBIN TOTAL	**1.2 mg/dL**	**High**	<0.0-1.0>
GGT	20 IU/L		<0-30>
LDH	175 IU/L		<110-220>

Patient Chart

[redacted] Date Printed: [redacted]

1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - IRON/IBC

Test Name	Result		Normal Range
07/14/10 09:20 AM			
% SAT	10 %	Low	<13-45>
IRON	25 ug/dL	Low	<40-145>
TIBC DIRECT	242 ug/dL	Low	<250-450>

Patient Chart

[redacted] Date Printed: 07/28/10

1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - LIPID PANEL

Test Name	Result		Normal Range
07/14/10 09:20 AM			
CHOLESTEROL	187 mg/dL		<0-200>
HDL-CHOL	43 mg/dL		<40-150>
LDL, DIRECT	112 mg/dL		<0-130>
CHOL/HDL RATIO	4.3		<0.0-4.4>
TRIGLYCERIDES	**158 mg/dL**	**High**	<35-135>

Patient Chart

[redacted]

Date Printed: 07/28/10

1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - PROTEIN STUDIES

Test Name	Result	Normal Range
07/14/10 09:20 AM		
ALBUMIN	4.1 g/dL	<3.8-5.5>
PROTEIN, TOTAL	6.7 g/dL	<6.3-8.3>

Patient Chart

[redacted] Date Printed: 07/28/10

[redacted] 1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - URINALYSIS

Test Name	Result		Normal Range
07/14/10 08:13 AM			
COLOR-UA	Yellow	Normal	<Yellow - Yellow>
CLARITY-UA	Clear	Normal	<Clear - Clear>
GLUC-UA	Negative	Normal	<Negative - Negative>
PROTEIN-UA	Negative	Normal	<NEGATIVE - NEGATIVE>
BILIRUBIN-UA	Negative	Normal	<Negative - Negative>
PH-UA	6.5	Normal	<5 - 8>
KETONES-UA	Negative QUAL	Normal	<Negative - Negative>
SP GRAV-UA	1.020	Normal	<1.001 - 1.035>
UROBILINOGEN-UA	0.2 E.U./dL E.U./dL	Normal	<0.1 - 1.0>
NITRITE-UA	Negative	Normal	<Negative - Negative>
WBC-UA	Trace #/HPF	Normal	<0 - 3>
BLOOD-UA	**1+**	**High**	<Negative - Negative>

Patient Chart

Date Printed: 07/28/10

[redacted] 1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - MISC. C's

Test Name	Result		Normal Range
07/14/10 09:20 AM			
CRP	2.42 mg/dL	High	<0.00-0.49>

Patient Chart

Date Printed: 07/28/10

[redacted] 1742 Sex: F Age: 55 DOB: [redacted]

Laboratory Data - MISC. E's

Test Name	Result		Normal Range
07/14/10 09:20 AM			
ESR (SED RATE)	46 mm/h	High	<0-15>

Danbury Hospital

Department of Pathology and Laboratory Medicine
24 Hospital Ave
Danbury, CT 06810
(203)739-7306

Patient: [redacted]
DOB/Age/Sex: [redacted] 55 years Female
Med Rec Number: [redacted]
Financial Number: [redacted]
Date of Service: 22-Nov-10
Consulting Providers: Reyes-Thomas, Joyce Wenick, Diane F

Location: LAB NO VISIT
Ordering Provider: Reyes-Thomas, Joyce
Copy To: Reyes-Thomas, Joyce

Pending Orders

Drawn Date	Drawn Time	Order Name	Department Status
22-Nov-10	20:08 EST	.ANCA IFA	Collected
22-Nov-10	20:08 EST	ANA IFA Reflex	In-Lab
22-Nov-10	20:08 EST	Sjogren's Autoantibodies	In-Lab

Chemistry

	Procedure	Sodium	Potassium	Chloride	HCO3 (TCO2)	BUN	Serum Creatinine
	Ref Range	[134-144]	[3.6-5.2]	[95-108]	[22-30]	[7-20]	[0.60-1.04]
	Units	mmol/L	mmol/L	mmol/L	mmol/L	mg/dL	mg/dL
22 Nov 2010	20:08 EST	141	4.5	103	24	24 H	0.75

	Procedure	eGFR-Non Afr Am	eGFR-Afr Am	Glucose	Anion Gap	Calcium Total
	Ref Range	[>=60]	[>=60]	[70-99]	[7-14]	[8.7-10.4]
	Units	mL/min/1.73sqm	mL/min/1.73sqm	mg/dL	mmol/L	mg/dL
22 Nov 2010	20:08 EST	>59	>59	107 H	14	10.1

	Procedure	Total Protein	Albumin	Globulin	A/G Ratio	Bilirubin Total	Alk Phos
	Ref Range	[6.3-8.2]	[3.6-4.9]			[0.2-1.3]	[38-126]
	Units	g/dL	g/dL	g/dL		mg/dL	U/L
22 Nov 2010	20:08 EST	8.0	4.6	3.4	1.4	0.4	68

	Procedure	ALT	AST
	Ref Range	[9-52]	[14-36]
	Units	U/L	U/L
22 Nov 2010	20:08 EST	34	21

LEGEND: e=Corrected *=Abnormal C=Critical L=Low H=High f=footnote

Danbury Hospital

Department of Pathology and Laboratory Medicine

Patient: [redacted]
DOB/Age/Sex: [redacted] 55 years Female
Med Rec Number: [redacted]
Financial Number: [redacted]

Location: LAB NO VISIT
Admitting Provider: Reyes-Thomas, Joyce

Chemistry

	Procedure Ref Range Units	HBsAg [Non-Reactive]	HBsAb [Non-Reactive]	HBcAb [Non-Reactive]	HAV-T [Non-Reactive]
22 Nov 2010	20:08 EST	Non-Reactive	**Reactive** *	Non-Reactive	Non-Reactive

22-Nov-10 20:08 EST HBsAb:
This Anti-HBs assay is traceable to the World Health Organization (WHO) Hepatitis B Immunoglobulin 1st Reference Preparation (1977). A reactive result indicates that Anti-HBs is detected at > or = 10 mIU/mL and the patient is considered to have protective immunity to HBV infection in accordance with CDC guidelines.

	Procedure Ref Range Units	Hep C Ab [Non-Reactive]
22 Nov 2010	20:08 EST	Non-Reactive

Electrophoresis

	Procedure Ref Range Units	SPEP Interpretation
22 Nov 2010	20:08 EST	See Below

22 Nov 2010 20:08 EST SPEP Interpretation
Normal protein distribution by electrophoresis. No discrete bands suggestive of monoclonal gammopathy.

11/23/10 17:03 By: Salvador F Sena Ph.D
(Electronic Signature)

Danbury Hospital

Department of Pathology and Laboratory Medicine

Patient: [redacted]
DOB/Age/Sex: [redacted] 55 years Female
Med Rec Number: [redacted]
Financial Number: [redacted]

Location: LAB NO VISIT
Admitting Provider: Reyes-Thomas, Joyce

Hematology

Blood Count

	Procedure	WBC	RBC	Hgb	Hct	MCV	MCH
	Ref Range	[4.0-10.0]	[3.70-5.00]	[12.0-16.0]	[36.0-46.0]	[80-99]	[25.0-35.0]
	Units	k/cumm	m/cumm	g/dL	%	fL	pg
22 Nov 2010	20:08 EST	8.6	4.45	13.3	39.4	89	29.9

	Procedure	MCHC	RDW CV	RDW SD
	Ref Range	[31.0-36.9]	[11.5-14.5]	[35.0-47.0]
	Units	g/dL	%	fL
22 Nov 2010	20:08 EST	33.8	12.9	41.5

Automated Differential

	Procedure	Neutro	Lymph	Mono	Eos	Baso	Imm Gran	Neutro #	Lymph #
	Ref Range	[40-75]	[16-46]	[4-12]	[0-7]	[0-2]	[0-1]	[1.8-7.8]	[1.0-3.4]
	Units	%	%	%	%	%	%	k/cumm	k/cumm
22 Nov 2010	20:08 EST	**88 H**	**12 L**	**1 L**	0	0	0	7.5	1.0

	Procedure	Mono #	Eos #	Baso #	Imm Gran #	Platelet Count	MPV
	Ref Range	[0.0-0.8]	[0.0-0.4]	[0.0-0.2]	[0.0-0.1]	[150-400]	[9.4-12.3]
	Units	k/cumm	k/cumm	k/cumm	k/cumm	k/cumm	fL
22 Nov 2010	20:08 EST	0.1	0.0	0.0	0.0	290	10.9

	Procedure	Sed Rate
	Ref Range	[0-20]
	Units	mm/hr
22 Nov 2010	20:08 EST	6

Immunology

	Procedure	Rheumatoid Fac	C-Reactive Protein	Myeloperoxidase Autoantibody
	Ref Range	[<=11.9]	[0.0-10.0]	[0-99]
	Units	IU/mL	mg/L	A unit/mL
22-Nov-10	20:08 EST	<8.6	<5.0	4

22-Nov-10 20:08 EST Myeloperoxidase Autoantibody:
Interpretation:

LEGEND: e=Corrected *=Abnormal C=Critical L=Low H=High f=footnote @=Ref Lab

Danbury Hospital

Department of Pathology and Laboratory Medicine

Patient: [redacted]
DOB/Age/Sex: [redacted] 55 years Female
Med Rec Number: [redacted]
Financial Number: [redacted]

Location: LAB NO VISIT
Admitting Provider: Reyes Thomas, Joyce

Immunology

<100 AU/mL = Negative
100 - 120 AU/mL = Equivocal
>120 AU/mL = Positive
Test performed by microparticle-based immunoassay.

	Procedure	Proteinase 3 Autoantibody	Lyme.	Lyme Reflex Note	C3 Complement
	Ref Range	[0-99]	[Negative]		[88-165]
	Units	A unit/mL			mg/dL
22-Nov-10	20:08 EST	7	Negative	See Note 1	**168 H**

22-Nov-10 20:08 EST Proteinase 3 Autoantibody:
Interpretation:
<100 AU/mL = Negative
100 - 120 AU/mL = Equivocal
>120 AU/mL = Positive
Test performed by microparticle-based immunoassay.

22-Nov-10 20:08 EST Lyme.:
Interpretation: Negative = No detectable antibody
Equivocal = Equivocal result, verified by repeat analysis
Follow up with clinical information and other available laboratory tests
(I.e., Immunoblotting) should be considered
Positive = Antibody Detected
Test performed by ELFA methodology

22-Nov-10 20:08 EST Lyme Reflex Note:
Lyme Elisa Negative. Per CDC Guidelines Western Blot testing not indicated

	Procedure	C4 Complement
	Ref Range	[10-40]
	Units	mg/dL
22-Nov-10	20:08 EST	17

[redacted] ID:000069142 28-JUL-2010 18:18:24 Danbury Hospital-ED ROUTINE RECORD

[redacted] (55 yr)
Female

Room:Z1 R8
Loc:13

Vent. rate	60	BPM
PR interval	178	ms
QRS duration	78	ms
QT/QTc	432/432	ms
P-R-T axes	28 18	47

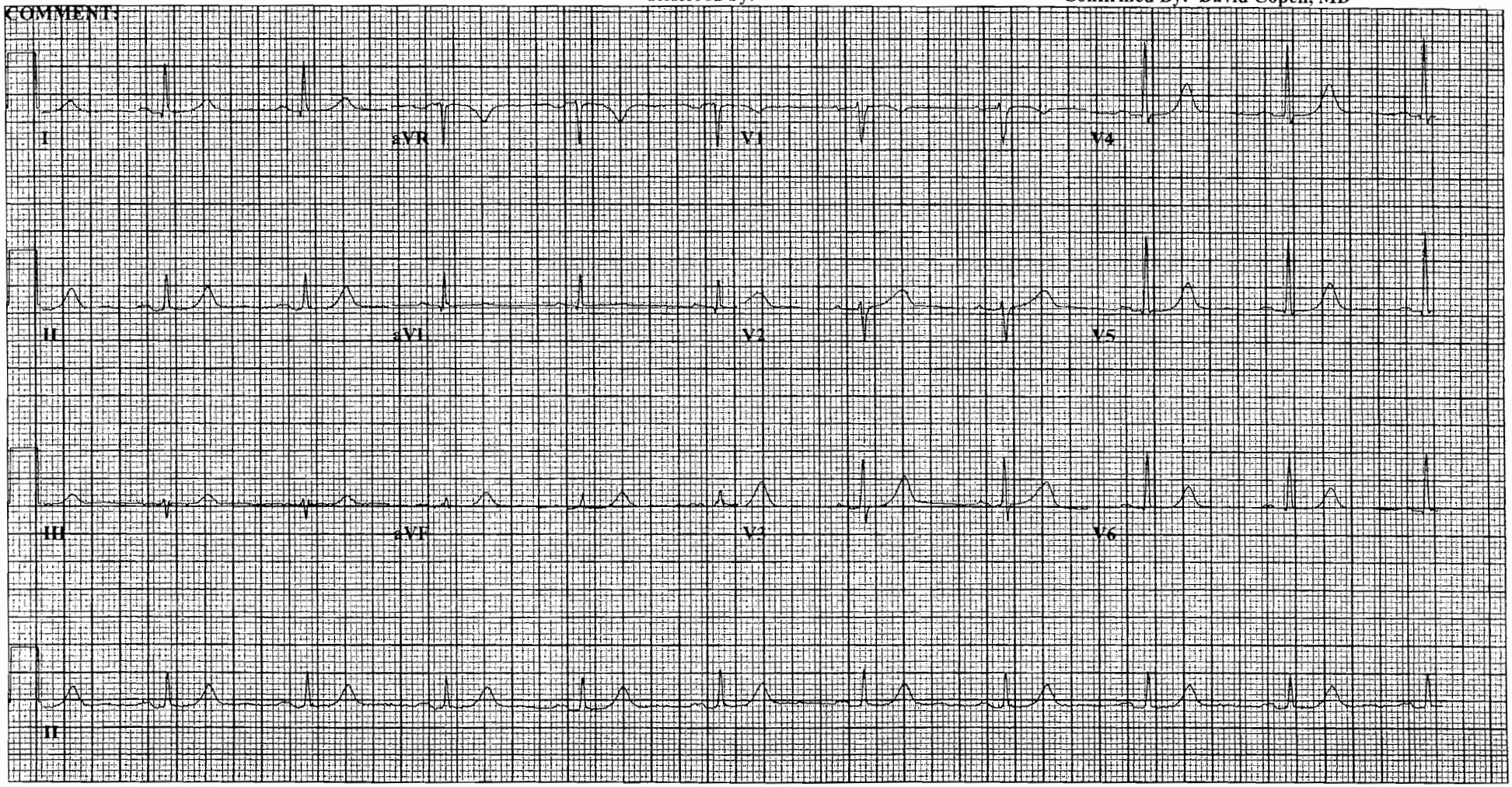
Normal sinus rhythm
Normal ECG
When compared with ECG of 12-APR-2010 21:26,
No significant change was found
Confirmed by Copen, MD, David (274) on 7/29/2010 12:32:43 PM

Technician: GO
Test ind:

Referred by:

Confirmed By: David Copen, MD

COMMENT:



25mm/s 10mm/mV 40Hz 7.1.1 12SL 237 CID: 29

SID: ED>8E EID:274 EDT: 12:32 29-JUL-2010 [redacted]

Eric Genden, MD, FACS
Department of Otolaryngology- Head and Neck Surgery

Patient Name: [redacted] Medical Record Number: [redacted]
Date: 10/11/2010

Referring Physician: Primary Care Physician:

[redacted] underwent an evaluation of a supraclavicular fossa mass that appears to be consistent with a lipoma. I have reviewed with her the findings on her needle biopsy and her imaging. She does still have pain that is consistent with neuralgia. It is not clear to me the cause of her pain. She is under the care of a neurologist and I have asked her to return to see the neurologist for evaluation. She has agreed to do so and will follow up with me if she develops any further symptoms related to the head and neck region.

Eric M. Genden, MD, FACS
Professor and Chairman,
Department of Otolaryngology-Head and Neck Surgery
Professor of Neurosurgery
Director, Head and Neck Cancer Center

EMG/ad

Eric Genden, MD, FACS
Department of Otolaryngology- Head and Neck Surgery

Patient Name: [redacted] Medical Record Number: [redacted]
Date: 09/16/2010

Referring Physician: Jeffrey Olin, D.O.
212-241-9454

Primary Care Physician:

History of Present Illness: This patient has had an extensive medical history, which is detailed as per her own records in the medical chart. However, essentially in January 2009, she developed rather significant left neck pain. The pain began in the left supraclavicular region and radiated up to the ear. She reports that the pain becomes debilitating because of the extensive and radiating nature. She does have a history of papillary thyroid carcinoma treated by Ashok Shaha at Memorial Sloan-Kettering and she received two doses of radioactive iodine. She has been under the care of Dr. Shaha and Dr. Tuttle since 2002. She had two doses of radioactive iodine, 278 millicuries in May 2000 and 314 millicuries in January 2003. The pain does not appear to be related to the thyroid surgery. The thyroid surgery and neck dissection were performed on the right lateral neck. Her pain is on the left side in the supraclavicular region. She has undergone a neurologic consult and was initially diagnosed with cervical plexus neuralgia. She was recommended to begin treatment with gabapentin, but never did so. She had a vascular workup, which demonstrated significant carotid loops, but no obvious vascular cause of pain. A CT scan performed at Mount Sinai was reviewed by me today. It demonstrates several small lymph nodes in the supraclavicular region, but fails to identify lesion that would be causing this pain.

Review of Systems: Negative.

Cardiovascular: Negative
Hem/Lymph: Negative
Skin/Breast: Negative
Respiratory: Negative
GI: Negative
GU: Negative

Constitutional:
Musculoskeletal:
Neuro: Negative
Psych: Negative
Endocrine: Negative
Allergy/Imm: Negative

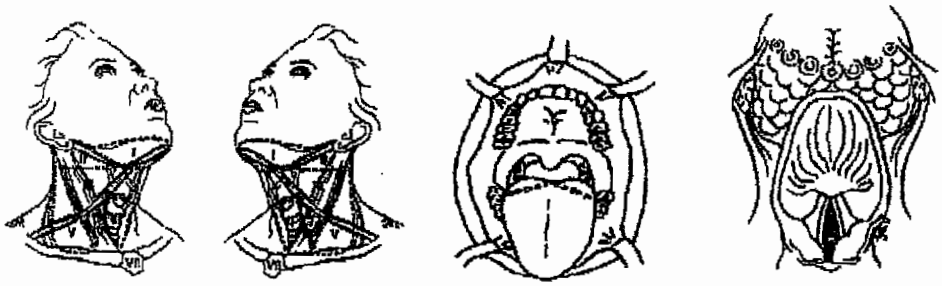
PATIENT QUESTIONNAIRE REVIEWED DATE:
PFSH:

PAST HISTORY:

MEDICATIONS: Cozaar, aspirin, estradiol, promethazine, fish oil, and vitamins.
ALLERGIES: See Attachment
CHRONIC DISEASES: See attachment
PRIOR HOSPITALIZATIONS, ILLNESSES, SURGERIES: The patient has an extensive surgical history including neck dissection and thyroidectomy in 2002 by Dr. Ashok Shaha, complete knee replacement in 2005, and surgery on her right arm for ulner disease.
MEDICAL HISTORY:

FAMILY HISTORY:
SOCIAL HISTORY: Negative

Eric Genden, MD, FACS
Department of Otolaryngology- Head and Neck Surgery



Exam
Constitutional
General Appearance: Normal

Neck
Lymph Nodes: There is a well-healed incision on the right lateral aspect of the neck and thyroid. There is fullness in the left supraclavicular region and it is clearly asymmetric when compared to the right side.

Thyroid: Normal exam, no thyromegaly, nodules or masses

Head and Face
Parotid Gland: Normal exam, no evidence of masses
Submandibular Gland: Normal exam, no evidence of masses

Oral Exam The oral cavity is normal without masses or lesions. There is no evidence of tonsillar masses or lesions.

Nose: External: Normal Exam
Septum: Normal exam

Ears: EAC: Normal canal, no infection or masses
TM: Normal tympanic membrane without perforation

IDL: Larynx and base of tongue are normal
SKIN: Normal exam
Eyes: PERRLA, EOMI

RESPIRATORY: Normal exam
Extremities: There is full range of motion in both the arms and does not appear to be atrophy of the biceps, triceps, or deltoid. Strength and movement are equivalent bilaterally.

Neurological: Non focal exam. Cranial nerves are intact

PLAN OF CARE (DIAGNOSIS, ASSESSMENT AND TREATMENT PLAN):
I have discussed with [redacted] the rather confusing nature of her presentation. I have recommended that she undergo an MRI of the neck, so I can more clearly elucidate and determine the nature of the asymmetry in the supreclavicular fossa.

Eric Genden, MD, FACS
Department of Otolaryngology- Head and Neck Surgery

She will undergo the study and I will review it and contact her regarding the findings. We will schedule a follow-up appointment based on the findings of the MRI.

Eric M. Genden, MD, FACS
Professor and Chairman,
Department of Otolaryngology-Head and Neck Surgery
Professor of Neurosurgery
Director, Head and Neck Cancer Center

EMG/ad

MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES
DEPARTMENT OF RADIOLOGY
MSK 68th
1275 York Avenue
New York, NY 10021
(212) 639-2000

PET

NUCLEAR MEDICINE
Report of Consultation

Name: [redacted]
MRN: [redacted]
DOB: [redacted] Sex: F
Ordered by: ROBERT M TUTTLE, MD
Procedure: NM PET SCAN
PRID #: [redacted]

Acc No: [redacted]
Date of Service: 07/07/2010
Pt Loc: MSK
Date of Report: 07/08/2010 05:08 PM
Account: [redacted]

Verified

00688884

July 7, 2010 Body FDG PET/CT

CLINICAL STATEMENT: Patient with thyroid cancer. Patient is referred for follow-up.

RADIOPHARMACEUTICAL: 12.3 mCi F-18 FDG.

TECHNIQUE: Following intravenous injection of F-18 FDG and an approximately 73 -minute uptake period, low-dose CT and PET images from the mid skull to the upper thighs were acquired on the Discovery ST PET/CT with the patient in the fasted state. Oral contrast material was administered. The CT protocol used for this PET/CT study is designed for attenuation correction and anatomic localization of PET abnormalities. This companion CT is not designed to produce, and cannot replace, state-of-the-art diagnostic CT scans with specific imaging protocols for different body parts and indications.

Plasma glucose at the time of this test: 78 mg/dl.

The standardized uptake values (SUV) are normalized to patient body weight and indicate the highest activity concentration (SUVmax) in a given disease site.

COMPARISON FDG PET/CT: May 17, 2002

OTHER STUDIES USED FOR CORRELATION: None

FINDINGS:

HEAD/FACE: Physiologic FDG uptake is seen in the visualized regions of the brain, large salivary glands and oropharynx.

NECK: Physiologic FDG uptake is seen in neck muscles.

CHEST: Physiologic FDG avidity is seen in

Diag.
Rad.

** Continued on next page **

mediastinal blood pool, myocardium.

LUNGS: No abnormal uptake.

PLEURA/PERICARDIUM: No abnormal uptake.

THORACIC NODES: No abnormal uptake.

LIVER/SPLEEN: No abnormal uptake. Liver background SUVmean, as a reference for comparing FDG studies, is 2.3.

PANCREAS: No abnormal uptake.

ADRENAL GLANDS: No abnormal uptake.

KIDNEYS/URETERS/
BLADDER: Excreted activity is seen.

ABDOMINOPELVIC NODES: No abnormal uptake.

BOWEL/PERITONEUM/
MESENTERY: No abnormal uptake.

PELVIC ORGANS: No abnormal uptake.

BONES/SOFT TISSUES: No abnormal uptake

EXTREMITIES: Normal tracer distribution.

OTHER FINDINGS: None

IMPRESSION:
1. Since May 17, 2002, there is no evidence for recurrent tumor

Dictated By: MAXINE JOCHELSON, MD
Staff Radiologist: MAXINE JOCHELSON, MD

I attest that the above IMPRESSION is based upon my personal examination of the entire imaging study and that I have reviewed and approved this report.

Electronically Signed By: MAXINE JOCHELSON, MD

ACC NUMBER: [redacted]
MEDICAL RECORD NUMBER: [redacted]

Diag.
Rad.

** End of Report **

Danbury Hospital Medical Arts Center

111 Osborne St.
Danbury, CT 06810

Patient: [redacted]
DOB/Age/Sex: [redacted] 56 years Female
Med Rec Number: [redacted]
Financial Number: [redacted]

Location: **MAC ODC STRESSTEST HEAR - -**
Copy To: N/A
Ordering Provider: Alexander, Jonathan
Admitting Provider: Alexander, Jonathan

Consulting Provider(s): Alexander, Jonathan Wenick, Diane F Wenick, Diane F

NUCLEAR CARDIOLOGY

203 739-7518

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	NC Regular Stress Test	01 Jul 2011 09:25 EDT	Alexander, Jonathan

Technical Comments

Reason for Test : Palpitations, Chest Pain
Clinical Information : Looped Carotid Artery, HTN, + FM HX
Medications : ASA, Synthroid, Cozaar
Exercised for (Time) : 9:04
Stage Obtained : 3
Reason for Terminating treadmill : Fatigue, Inability to maintain speed and grade
Base line HR : 69
Base line BP : 116/83
Max HR : 153
Max BP : 169/80
% HR Achieved : 93%
Performed By (Licensed Medical Provider) : Jan VanWart, APRN
Supervising Physician : Jeffrey Schmierer, M.D.

Report

_Exercise Report:
the patient exercised for 9 minute 4 seconds achieving a peak heart rate 153 representing 93% of age-predicted max heart rate test was stopped because of fatigue.
ECG:
baseline EKG demonstrates sinus rhythm without ST segment abnormality. EKGs obtained during exercise demonstrated nonspecific nonischemic changes of the ST segments. There is no arrhythmia.
Summary:

Danbury Hospital Medical Arts Center

Patient: [redacted]
DOB/Age/Sex: [redacted]56 years Female
Med Rec Number: [redacted]
Financial Number: [redacted]

Location: **MAC ODC STRESSTEST HEAR - -**
Copy To: Alexander, Jonathan
Ordering Provider: Alexander, Jonathan
Admitting Provider: Alexander, Jonathan

NUCLEAR CARDIOLOGY
203 739-7518

Accession Number	Exam	Exam Date/Time	Ordering Physician
[redacted]	NC Regular Stress Test	01 Jul 2011 09:25 EDT	Alexander, Jonathan

this is A negative nonischemic exercise tolerance test performed at a high workload and diagnostic heart rate.

***** Final Report *****
Reported By: Schmierer, Jeffrey A M.D.
Dictated by : Schmierer, Jeffrey A M.D.
Signed: 07/01/2011 12:48

DANBURY OFFICE OF
PHYSICIAN SERVICES, PC

Cardiovascular Services

Date: 05/23/2011

Re: [redacted]
DOB: [redacted]

Reason For Visit
Follow-up visit for problems listed under Assessment

HPI
The patient presents today with symptoms of palpitations occurring predominantly at night sensation of head rushing.. These have increased since atenolol was discontinued. They are often associated exertion as well. She has occasional exertional dyspnea as well. There is no chest pain per se. Her blood pressure is under good control recently.

Active Problems
Chest Pain (786.50)
Headache (784.0)
Palpitations (785.1)
Temporal Arteritis (446.5).

PMH
The patient had thyroid cancer and underwent a thyroidectomy in 2002. She is currently on thyroid replacement therapy.

PSH
Status post knee replacement in December of 2005. Status post thyroidectomy in 2002 for a thyroid cancer. Status post breast surgery in 1993 and 1995.

Family Hx
No change from previous visit.

Personal Hx
No change from previous visit.

ROS
CONSTITUTIONAL: Appetite good, no fevers, night sweats or weight loss
CV: No chest pain, shortness of breath or peripheral edema
RESPIRATORY: No cough, wheezing or dyspnea
GI: No nausea/vomiting, abdominal pain, or change in bowel habits
GU: No dysuria, urgency or incontinence
NEURO: No MS changes, no motor weakness, no sensory changes.

Allergies
No Known Drug Allergy.

Current Meds
Synthroid 150 MCG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Cozaar 50 MG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Estradiol 1 MG Oral Tablet;TAKE 1 TABLET DAILY.; RPT
Prometrium 100 MG Oral Capsule;TAKE 1 CAPSULE DAILY; RPT
Multivitamins TABS;TAKE 1 TABLET DAILY.; RPT
Fish Oil 1000 MG Oral Capsule;TAKE 1 CAPSULE DAILY.; RPT
Aspirin 81 MG Oral Tablet;TAKE TABLET one every other day; RPT
Vitamin D3 1000 UNIT Oral Capsule;TAKE AS DIRECTED.; RPT
Vitamin B Complex Oral Capsule;TAKE 1 CAPSULE DAILY.; RPT

Caltrate 600+D 600-400 MG-UNIT Oral Tablet Chewable;TAKE 2 TABLET DAILY; RPT.

Vital Signs

Recorded by Carroll,Michelle on 23 May 2011 03:37 PM
BP:122/80,
HR: 72 b/min,
Height: 65 in, Weight: 186 lb, BMI: 31 kg/m2,
BSA Calculated: 1.92 ,
BMI Calculated: 30.95.

Physical Exam

GEN: no apparent distress
Neck: Normal JVP
Cardiovascular: Regular, S1 S2, no rubs, gallops, or murmurs.
Respiratory: Clear to auscultation bilaterally, no rales
Extremities: No edema.

Results

Echocardiogram from November 10, 2010 (Mount Sinai Medical Center in New York): Low normal left ventricular ejection fraction equals 53%. Atrial septal defect/atrial septal aneurysm with a small left to right shunt. Abnormal left ventricular diastolic filling pattern. Normal right ventricular size and function. No evidence for aortic valve stenosis. Minimal aortic regurgitation.

ECHOCARDIOGRAM (Echo) 19 May 2011 10:38 AM
- REPORT
Interpretation Summary
Compared to prior study of 21508 there is no significant change.
Conclusion
Normal global LV size and systolic function. The estimated left ventricular ejection fraction is 60-65%. No regional wall motion abnormalities noted. The right ventricle is normal in size and function. The left atrium is mildly dilated. The interatrial septum bows toward right atrium consistent with elevated left atrial pressure. Doppler suggests left to right interatrial shunt (PFO versus ASD). There is no pulmonary hypertension.
LEFT VENTRICLE:
There is normal left ventricular wall thickness.
Normal global LV size and systolic function.
The estimated left ventricular ejection fraction is 60-65%.
No regional wall motion abnormalities noted.
RIGHT VENTRICLE:
The right ventricle is normal in size and function.
There is no pulmonary hypertension.
ATRIA:
The left atrium is mildly dilated.
Right atrial size is normal.
The interatrial septum bows toward right atrium consistent with elevated left atrial pressure.
Doppler suggests left to right interatrial shunt.
MITRAL VALVE:
The mitral valve is normal in structure and function.
There is trace mitral regurgitation.
TRICUSPID VALVE:
The tricuspid valve is normal.
There is trace tricuspid regurgitation.
AORTIC VALVE:
Mild aortic valve sclerosis without stenosis.
No aortic regurgitation is present.
PULMONIC VALVE:
The pulmonic valve leaflets are thin and pliable; valve motion is normal.
Trace pulmonic valvular regurgitation.

GREAT VESSELS:
The ascending aorta is normal
The pulmonary artery is normal size.
PERICARDIUM/PLEURAL:
There is no pericardial effusion.
CPT:
Two dimensional sector scanning, Doppler color flow imaging, and pulsed and continuous wave Doppler interrogation.
Sonographer Comments
Previous Study in Xcelera
STUDY QUALITY:
The quality of the study is mildly reduced by poor acoustical penetration
DIASTOLIC FUNCTION
Diastolic function is consistent with impaired relaxation
Patient Height 65.0in
Patient Weight 168.0lbs
Study Location: DANBURY HOSPITAL
Doppler Measurements and Calculations
MV A point 73.5cm/sec
MV E point 58.2cm/sec
Ao max PG 8.2mmHg
Ao V2 max 143.5cm/sec
LV V1 max 98.2cm/sec
LV max PG 3.9mmHg
PA V2 max 95.0cm/sec
PA max PG 3.6mmHg
TR Max vel 211.7cm/sec
MV dec time 0.3sec
Lat A' vel 11.8cm/sec
Lat Peak E' Vel 7.8cm/sec
E/E' lat 7.5
MV E/A 0.8
RVSP 27.9mmHg
MMode 2D Measurements and Calculations
IVSd 0.9cm
LA dimension 3.9cm
LVIDd 4.0cm
LVIDs 2.5cm
LVPWd 0.9cm
asc Aorta 3.1cm
Interpreting Physician:Ira Galin,MD electronically signed on 05-19-2011 12:33:36.
5/23/11 EKG reveals normal sinus rhythm and is within normal limits. It is unchanged compared to prior tracings.

Impression/Plan

I reassured the patient about the unchanged echocardiogram and normal EKG. She will have a 48-hour Holter monitor regular stress test to see if any arrhythmias are present. I will see her afterwards to review the results. Her blood pressures under very good control for.

Assessment

- Palpitations (785.1)
- Chest pain (786.50)

Orders

~~LIPIDS WITH AST(Quest # 300474); Requested for: 23 May 2011.~~
~~Follow-up visit in 1 year; Requested for: 23 May 2011.~~
HOLTER MONITORING 24HR (Holter Monitor Hook Up Scan 24hr); Requested for: 23 May 2011.
REGULAR STRESS TEST (Regular Treadmill); Requested for: 23 May 2011.
Follow-up visit in 2 weeks; Requested for: 23 May 2011.

Re: [redacted]

DOB: [redacted]

Coun/Edu

HYPERTENSION:
Risk and potential complications of hypertension were reviewed with the patient.
Treatment plan and follow-up was reviewed and understood by the patient.
Instructed to call for:
--Chest pain or discomfort
--Change in heart rate, rhythm or strength
--Shortness of breath or swelling of feet/ankles
--Headaches not relieved with OTC medication
--New, unexplained symptoms develop.

Signature

Electronically signed by : Michelle Carroll ; 05/23/2011 3:40 PM EST.
Electronically signed by : JONATHAN ALEXANDER MD; 05/23/2011 5:24 PM EST.